General

Guideline Title

Depression.

Bibliographic Source(s)

University of Michigan Health System. Depression. Ann Arbor (MI): University of Michigan Health System; 2011 Aug. 23 p. [7 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: University of Michigan Health System. Depression. Ann Arbor (MI): University of Michigan Health System; 2005 Oct. 20 p.

Recommendations

Major Recommendations

Note from the University of Michigan Health System (UMHS) and the National Guideline Clearinghouse (NGC): The following guidance was current as of August 2011. Because UMHS occasionally releases minor revisions to its guidance based on new information, users may wish to consult the original guideline document for the most current version.

Note from NGC: The following key points summarize the content of the guideline. Refer to the full text of the original guideline document for detailed information on diagnosis, treatment, and medications.

The strength of recommendation (I-III) and levels of evidence (A-D) are defined at the end of the "Major Recommendations" field.

Epidemiology

- Common. Depression is common, under-diagnosed, and under-treated.
- Recurrent. Depression is frequently a recurrent/chronic disorder, with a 50% recurrence rate after the first episode, 70% after the second, and 90% after the third.
- Care provider. Most depressed patients will receive most or all of their care through primary care physicians.

Diagnosis

Depressed patients frequently present with somatic complaints to their primary care doctor rather than complaining of depressed mood *[C]*.

Treatment

Mild major depression can be effectively treated with either medication or psychotherapy. Moderate to severe or chronic depression may require an approach combining medication and psychotherapy *[IIA]*.

- Drug treatment. 40%-50% of patients respond to the first antidepressant *[A]*. No particular antidepressant agent is superior to another in efficacy or time to response. Choice is often guided by matching patients' symptoms to side effect profile, presence of medical and psychiatric co-morbidity, and prior response *[IIA]*. Relative costs can also be considered because of the large selection of antidepressants available in generic form. Patients treated with antidepressants should be closely observed for possible worsening of depression or suicidality, especially at the beginning of therapy or when the dose increases or decreases *[IC]*.
- Frequent initial visits. Patients require frequent visits early in treatment to assess response to intervention, suicidal ideation, side effects, and psychosocial support systems *[ID]*.
- Continuation therapy. Continuation therapy (9-12 months after acute symptoms resolve) decreases the incidence of relapse of major depression *[IA]*. Long-term maintenance or life-time drug therapy should be considered for selected patients based on their history of relapse and other clinical features *[IIB]*.
- Education/support. Patient education and support are essential. Social stigma and patient reluctance to accept a diagnosis of depression or enter treatment continue to be a problem *[IIC]*.

Definitions:

Levels of Evidence

A. Randomized controlled trials
B. Controlled trials, no randomization
C. Observational trials
D. Opinion of expert panel

Strength of Recommendation

I. Generally should be performed
II. May be reasonable to perform
III. Generally should not be performed

Clinical Algorithm(s)

An algorithm is provided in the original guideline document for an overview of treatment for depression.

Scope

Disease/Condition(s)

Depression, including:

- Major depressive disorder (MDD)
- Dysthymia
- Minor depression
- Seasonal affective disorder (SAD)
- Mood disorders associated with a general medical condition
- Bereavement
- Bipolar disorder

Guideline Category

Diagnosis

Evaluation

Management

Screening

Treatment

Clinical Specialty

Family Practice

Internal Medicine

Obstetrics and Gynecology

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Social Workers

Guideline Objective(s)

- To improve the early recognition and treatment of depression in the primary care setting
- To improve patient's understanding of depression and its treatment
- To familiarize clinicians with appropriate treatment options, i.e., medication and psychotherapies
- To identify when referral is indicated

Target Population

Adults with depressive disorders

Interventions and Practices Considered

Screening and Diagnosis

1. Use of Diagnostic and Statistical Manual of Mental Illness-IV (DSM-IV) criteria for diagnosis of major depression
2. Patient Health Questionnaire (PHQ-9)
3. History (family history, history of prior manic or hypomanic episodes, substance abuse, and other comorbid disorders)
4. Evaluation of severity, suicidal tendencies, and psychotic features
5. Physical examination
6. Laboratory testing (not recommended routinely)

Treatment/Management

1. Supportive care
    - Patient education

    - Exercise
2. Pharmacotherapy
    - Selective serotonin reuptake inhibitors (SSRIs)
        - Citalopram
        - Escitalopram
        - Fluoxetine
        - Paroxetine
        - Sertraline
    - Serotonin-2 antagonist/reuptake inhibitor: nefazodone
    - Serotonin/norepinephrine reuptake inhibitor (SNRIs)
        - Venlafaxine
        - Desvenlafaxine
        - Duloxetine
    - Serotonin and alpha-2 receptor blocker: mirtazapine
    - Norepinephrine/dopamine reuptake inhibitor: bupropion
3. Psychotherapy
    - Any psychotherapy
    - Interpersonal psychotherapy (IPT)
    - Cognitive behavioral psychotherapy (CBT)
    - Marital therapy
4. Ongoing clinical assessment
5. Treatments for severe or refractory depression: antidepressant combination, lithium, thyroid hormone supplementation, antipsychotic medication, electroconvulsive therapy, stimulant medication, monoamine oxidase inhibitors (MAOIs), mood stabilizers, referral
6. Management of side effects of therapy
7. Special considerations in adolescents and older patients
8. St. John's wort and management of withdrawal syndrome (controversial areas)

Major Outcomes Considered

- Mortality rates by suicide
- Depressive symptoms
- Frequency and severity of relapses
- Outpatient visits and inpatient hospitalization
- Mortality from myocardial infarction and cerebrovascular accident (CVA)
- Direct and indirect costs (including direct patient care, time lost from work, and potential income loss due to suicide) associated with major depressive disorder

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

The literature search for this update began with results of the literature search performed in 1997 to develop the initial guideline released in 1998 and the search performed in 2002 for the update released in 2004. The literature search for this update used keywords that were very similar to those used in the previous searches. However, instead of beginning the search with literature in 2002, the guideline team accepted the search strategy and results for the search performed through 12/31/06 for the Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guideline for Management of Major Depressive Disorder (MDD).

The search for this update was conducted prospectively on Medline using the major keywords of: depression, depressive disorders; clinical

guidelines, controlled clinical trials, cohort studies; adults; English language, and published 1/1/07–1/31/10. Terms used for specific topic searches within the major key words included: epidemiology, national cost of treatment (economics); spectrum of depression, seasonal affective disorder, dysthymia; screening for depression; screening for bipolar disorder; diagnosis; suicide risk assessment; patient education; exercise; pharmacotherapy and psychotherapy – comparison and in combination; combinations of more than one pharmacologic agent; serotonin selective reuptake inhibition (citalopram, escitalopram, fluoxetine, paroxetine, sertraline); serotonin/norepinephrine reuptake inhibition (desvenlafaxine, duloxetine, mirtazapine, tricyclic antidepressants, venlafaxine); norepinephrine/dopamine reuptake inhibition (bupropion); serotonin-2 antagonist/reuptake inhibition (nefazodone, trazodone); St. John's wort (Hypericum Perforatum); maintenance on pharmacotherapy, continuation duration; withdrawal syndrome (paroxetine/Paxil, desvenlafaxine, venlafaxine); medication adherence; managing sexual side effects of pharmacologic agents; pregnancy and pharmacologic agents; breast feeding and pharmacologic agents; pharmacotherapy not included above; mindfulness based therapy; problem solving therapy; interpersonal psychotherapy, cognitive behavioral therapy, short-term or focal psychodynamic psychotherapy, marital therapy, psychotherapy, not included above; other treatment not included above; ongoing clinical assessment; medical comorbidity; alcohol abuse; panic (including generalized anxiety disorder or phobia); obsessive compulsive disorder; post-traumatic stress disorder; eating disorders and anorexia nervosa; partner violence; sexual assault; pregnancy (not included above); postpartum (not included above); and depression not included above. Specific search strategy available upon request.

The search was conducted in components each keyed to a specific causal link in a formal problem structure (available upon request). The search was supplemented with very recent clinical trials known to expert members of the panel. Negative trials were specifically sought. The search was a single cycle.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

A. Randomized controlled trials
B. Controlled trials, no randomization
C. Observational trials
D. Opinion of expert panel

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Conclusions were based on prospective randomized controlled trials (RCTs) if available, to the exclusion of other data; if randomized controlled

trials were not available, observational studies were admitted to consideration. If no such data were available for a given link in the problem formulation, expert opinion was used to estimate effect size.

Rating Scheme for the Strength of the Recommendations

Strength of Recommendation

I. Generally should be performed
II. May be reasonable to perform
III. Generally should not be performed

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Peer Review

Description of Method of Guideline Validation

Drafts of this guideline were reviewed in clinical conferences and by distribution for comment within departments and divisions of the University of Michigan Medical School to which the content is most relevant: Family Medicine, General Medicine, General Obstetrics & Gynecology, and Psychiatry. The Executive Committee for Clinical Affairs of the University of Michigan Hospitals and Health Centers endorsed the final version.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Conclusions were based on prospective randomized controlled trials (RCTs) if available, to the exclusion of other data; if RCTs were not available, observational studies were admitted to consideration. If no such data were available for a given link in the problem formulation, expert opinion was used to estimate effect size.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Recognition and accurate diagnosis of depression
- Appropriate treatment of depression, with accompanying improvement in patient mood and functioning
- Appropriate continuation and maintenance therapy to decrease the incidence of relapse of major depression
- Cost-effective prescription of antidepressant medications

Subgroups Most Likely to Benefit

Table 5 in the original guideline document includes patient profiles most likely to benefit from specific drugs.

Potential Harms

Side Effects Associated with Antidepressant Agents

- Insomnia
- Akathisia (a syndrome characterized by muscle restlessness)
- Weight gain
- Sexual dysfunction

Refer to Table 5 in the original guideline document for side effect information for specific antidepressants as well as selected important drug interactions, pregnancy and lactation risk categories, and patients least likely to benefit from selected antidepressants.

Contraindications

Contraindications

- Duloxetine is not to be prescribed ordinarily if concurrent heavy alcohol use and/or evidence of chronic liver disease.
- Do not use bupropion (Wellbutrin) if history of seizure, head trauma, substance abuse, bulimia, anorexia or electrolyte disturbance.
- Paroxetine should be avoided in pregnancy due to evidence of fetal cardiac malformations (although recent studies question this finding).
- Refer to Table 5 in the original guideline for drug combinations that should not be used, particularly combination of selected antidepressants with monoamine oxidase inhibitors (MAOIs).

Qualifying Statements

Qualifying Statements

These guidelines should not be construed as including all proper methods of care or excluding other acceptable methods of care reasonably directed to obtaining the same results. The ultimate judgment regarding any specific clinical procedure or treatment must be made by the physician in light of the circumstances presented by the patient.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Chart Documentation/Checklists/Forms

Clinical Algorithm

Patient Resources

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

University of Michigan Health System. Depression. Ann Arbor (MI): University of Michigan Health System; 2011 Aug. 23 p. [7 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

1998 Jun (revised 2011 Aug)

Guideline Developer(s)

University of Michigan Health System - Academic Institution

Source(s) of Funding

University of Michigan Health System

Guideline Committee

Depression Guideline Team

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

The University of Michigan Health System endorses the Guidelines of the Association of American Medical Colleges and the Standards of the Accreditation Council for Continuing Medical Education that the individuals who present educational activities disclose significant relationships with commercial companies whose products or services are discussed. Disclosure of a relationship is not intended to suggest bias in the information presented, but is made to provide readers with information that might be of potential importance to their evaluation of the information.

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Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: University of Michigan Health System. Depression. Ann Arbor (MI): University of Michigan Health System; 2005 Oct. 20 p.

Guideline Availability

Electronic copies: Available from the University of Michigan Health System Web site .

Availability of Companion Documents

The following is available:

- Continuing Medical Education (CME) information is available from the University of Michigan Health System Web site .

The Patient Health Questionnaire-2 (PHQ-2) and PHQ-9 forms are available in the original guideline document .

Patient Resources

The following is available:

- Beyond sadness. Ann Arbor: University of Michigan Health System; 2002. 2 p. Electronic copies: Available in Portable Document Format (PDF) from the University of Michigan Health System Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This summary was completed by ECRI on May 20, 1999. The information was verified by the guideline developer on June 17, 1999. This NGC

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